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Medicare Advantage Policy Manual

Policy ID: M-SUR149

Surgical Ventricular Restoration

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IMPORTANT REMINDER

The Medicare Advantage Medical Policy manual is not intended to override the member Evidence of Coverage (EOC), which defines the insured's benefits, nor is it intended to dictate how providers are to practice medicine. Physicians and other health care providers are expected to exercise their medical judgment in providing the most appropriate care for the individual member, including care that may be both medically reasonable and necessary.

The Medicare Advantage medical policies are designed to provide guidance regarding the decision-making process for the coverage or non-coverage of services or procedures in accordance with the member EOC and Centers of Medicare and Medicaid Services (CMS) policies and manuals, along with general CMS rules and regulations. In the event of a conflict, applicable CMS policy or EOC language will take precedence over the Medicare Advantage Medical Policy. In the absence of a specific CMS coverage determination for a requested service, item or procedure, the health plan may apply CMS regulations, as well as their Medical Policy Manual or other applicable utilization management vendor criteria developed with an objective, evidence-based process using scientific evidence, current generally accepted standards of medical practice, and authoritative clinical practice guidelines.

Some services or items may appear to be medically indicated for an individual, but may be a direct exclusion of Medicare or the member's benefit plan. Medicare and member EOCs exclude from coverage, among other things, services or procedures considered to be investigational (experimental) or cosmetic, as well as services or items considered not medically reasonable and necessary under Title XVIII of the Social Security Act, §1862(a)(1)(A). In some cases, providers may bill members for these non-covered services or procedures. Providers are encouraged to inform members in advance when they may be financially responsible for the cost of non-covered or excluded services. Members, their appointed representative, or a treating provider can request coverage of a service or item by submitting a pre-service organization determination prior to services being rendered.

DESCRIPTION

Surgical ventricular restoration (SVR) is a procedure designed to restore or remodel the left ventricle to its normal, spherical shape and size in patients with akinetic segments of the heart, secondary to either dilated cardiomyopathy or post infarction left ventricular aneurysm. It is usually performed after coronary artery bypass grafting (CABG) and may precede or be followed by mitral valve repair or replacement and other procedures such as endocardectomy and cryoablation for treatment of ventricular tachycardia.

MEDICARE ADVANTAGE POLICY CRITERIA

Note: This policy only addresses **surgical ventricular restoration** (SVR), which may also be referred to as ventricular remodeling, surgical anterior ventricular endocardial restoration

(SAVER) or the Dor procedure. It does not address **partial ventriculectomy** (aka, the Batista procedure). CPT guidelines state to report the Batista procedure with CPT code 33999. The Medicare NCD for *Partial Ventriculectomy* ([20.26](#)) considers this service to be non-covered. A key difference between surgical ventricular restoration and ventriculectomy (i.e., for aneurysm removal) is that in SVR circular “purse string” suturing is used around the border of the aneurysmal scar tissue. Additionally, SVR is distinct from partial left ventriculectomy (i.e., the Batista procedure) which does not attempt to specifically resect akinetic segments and restore ventricular contour.

CMS Coverage Manuals*	None
National Coverage Determinations (NCDs)*	None
Noridian Healthcare Solutions (Noridian) Local Coverage Determinations (LCDs) and Articles (LCAs)*	None
Medical Policy Manual	<p><i>Medicare coverage guidance is not available for surgical ventricular restoration. Therefore, the health plan’s medical policy is applicable.</i></p> <p>Surgical Ventricular Restoration, Surgery, Policy No. 149 (see “NOTE” below)</p>

NOTE: If a procedure or device lacks scientific evidence regarding safety and efficacy because it is investigational or experimental, the service is noncovered as not reasonable and necessary to treat illness or injury. ([Medicare IOM Pub. No. 100-04, Ch. 23, §30 A](#)). According to Title XVIII of the Social Security Act, §1862(a)(1)(A), only medically reasonable and necessary services are covered by Medicare. In the absence of a NCD, LCD, or other coverage guideline, CMS guidelines allow a Medicare Advantage Organization (MAO) to make coverage determinations, applying an **objective, evidence-based process, based on authoritative evidence**. ([Medicare IOM Pub. No. 100-16, Ch. 4, §90.5](#)). The Medicare Advantage Medical Policy - Medicine Policy No. M-149 - provides further details regarding the plan’s evidence-assessment process (see Cross References).

POLICY GUIDELINES

REGULATORY STATUS

The CorRestore™ Patch System is a device U.S. Food and Drug Administration (FDA)-approved through the 510(k) process specifically labeled for use “as an intracardiac patch for cardiac reconstruction and repair.” The device consists of an oval tissue patch made from glutaldehyde fixed bovine pericardium. It is identical to other marketed bovine pericardial patches except that it incorporates an integral suture bolster in the shape of a ring that is used along with ventricular sizing devices, to restore the normal ventricular contour. Note, the fact a new service or procedure has been issued a CPT/HCPCS code or is FDA approved for a

specific indication does not, in itself, make the procedure medically reasonable and necessary. The FDA determines safety and effectiveness of a device or drug, but does not establish medical necessity. While Medicare may adopt FDA determinations regarding safety and effectiveness, CMS or Medicare contractors evaluate whether or not the drug or device is reasonable and necessary for the Medicare population under §1862(a)(1)(A).

CROSS REFERENCES

[Investigational \(Experimental\) Services, New and Emerging Medical Technologies and Procedures, and Other Non-Covered Services](#), Medicine, Policy No. M-149

[Ventricular Assist Devices and Total Artificial Hearts](#), Surgery, Policy No. M-52

REFERENCES

None

CODING

Codes	Number	Description
CPT	33548	Surgical ventricular restoration procedure, includes prosthetic patch, when performed (eg, ventricular remodeling, SVR, SAVER, DOR procedure)
	0643T	Transcatheter left ventricular restoration device implantation including right and left heart catheterization and left ventriculography when performed, arterial approach
HCPCS	None	

***IMPORTANT NOTE:** Medicare Advantage medical policies use the most current Medicare references available at the time the policy was developed. Links to Medicare references will take viewers to external websites outside of the health plan's web control as these sites are not maintained by the health plan.